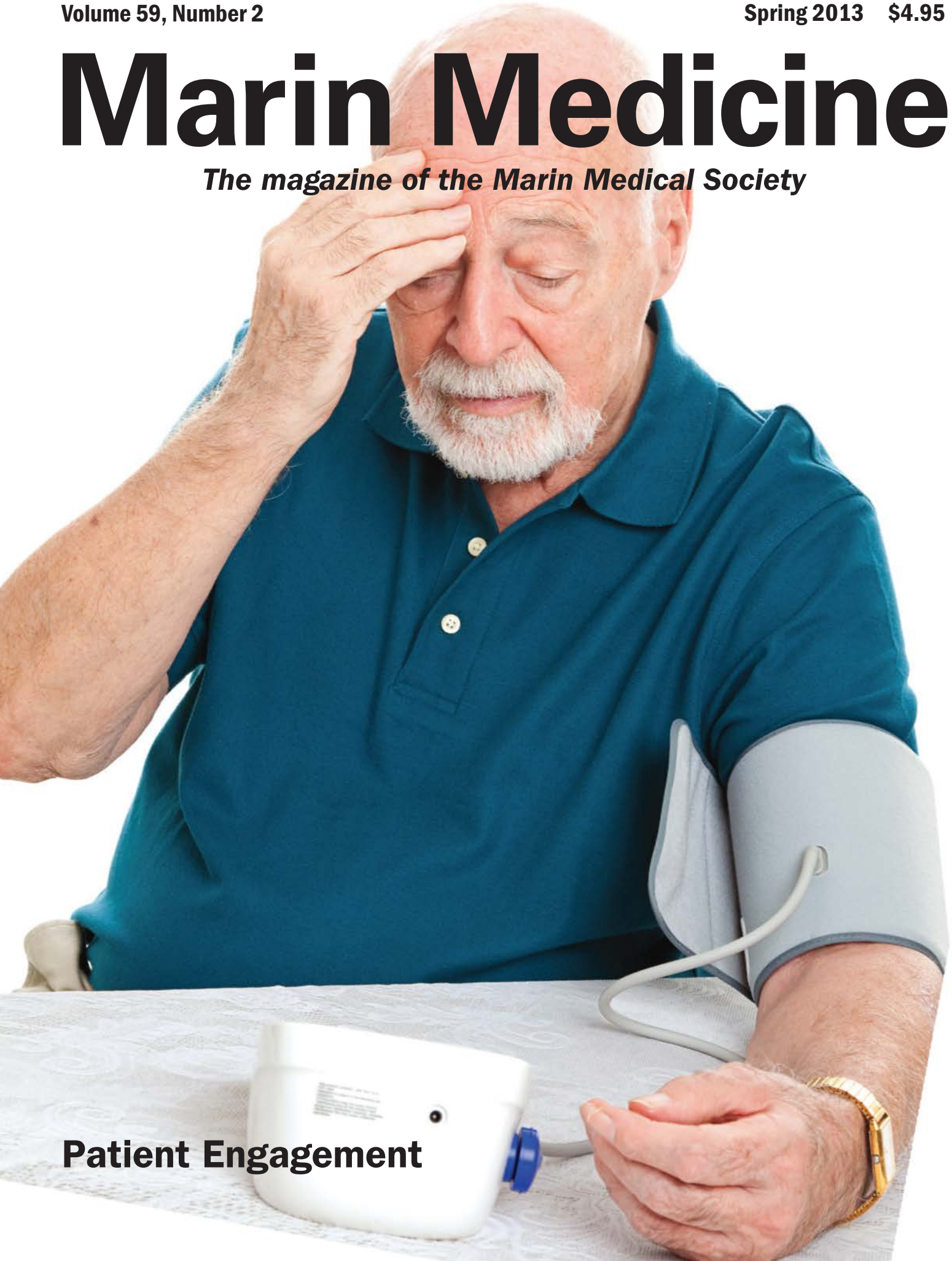
Volume 59, Number 2 Spring 2013 $4.95

Marin Medicine

The magazine of the Marin Medical Society



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Marin Medicine (ISSN 1941-1835) is the official quarterly magazine of the Marin Medical Society, 2901 Cleveland Ave. #202, Santa Rosa, CA 95403. Periodicals postage paid at Santa Rosa, CA.
POSTMASTER: Send address changes to *Marin Medicine*, 2901 Cleveland Ave. #202, Santa Rosa, CA 95403.

Opinions expressed by authors are their own, and not necessarily those of *Marin Medicine* or the medical society. The magazine reserves the right to edit or withhold advertisements. Publication of an advertisement does not represent endorsement by the medical association.

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The subscription rate is $19.80 per year (four quarterly issues). For advertising rates and information, contact Erika Goodwin at 707-548-6491 or visit marinmedicalsociety.org/magazine.

Printed on recycled paper.

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Does patient engagement work?

Paul Wasserstein, MD

Four new federal programs (value-based purchasing, meaningful use of electronic records, monitoring hospital readmissions, and creating accountable care organizations) will significantly impact hospitals and physicians through the use of Medicare penalties and incentives. In order to qualify for the incentives and avoid penalties, hospitals and physicians will have to employ new "patient engagement" strategies that actually work to decrease costs and improve outcomes and the overall patient experience. But no one seems to agree on the definition of patient engagement. Maybe it's this (from a recent healthcare blog):

"Patient engagement is shared responsibility between patients, healthcare practitioners, and healthcare administrators to co-develop pathways to optimal individual, community and population health. Patient engagement brought to life means involving patients and caregivers in every step of the process, providing training or financial support if necessary to their participation."[1]

But does patient engagement work? The evidence to date is mixed. A few patient-engagement projects appear to have generated some savings and better quality scores, but the reduction in per-capita costs pales in comparison to the estimated 35% of U.S. healthcare dollars spent on care that is inefficiently delivered or doesn't improve health.[2]

Dr. Wasserstein serves on the MMS Board of Directors and is a pathologist with offices in Novato and Greenbrae.

Patient-engagement projects that have demonstrated success include several in Boston, Miami, Los Angeles and Seattle. On average, the risk-adjusted per-capita health spending at these projects was around 15–20% below the regional average. Of interest is that most of the projects accomplished these savings without significant health information system support!

The Seattle project, called an Intensive Outpatient Care Program (IOCP), has been described in detail by Dr. Arnold Milstein, professor of medicine at Stanford University, director of the Stanford Clinical Excellence Research Center, and medical director of The Pacific Business Group on Health. He writes:

"The pilot enrolled 740 eligible non-Medicare Boeing patients being treated by physicians at the Everett Clinic, Valley Medical Center IPA, and Virginia Mason Medical Center clinics. Patients who accepted were connected to a care team that included a dedicated RN care manager and an IOCP-participating MD. . . . Each IOCP-enrolled patient received a comprehensive intake interview, physical exam, and diagnostic testing. A care plan was developed in partnership with the patient. The plan was executed through intensive in-person, telephonic and email contacts—including frequent proactive outreach by an RN, education in self-management of chronic conditions, rapid access to and care coordination by the IOCP team, daily team planning huddles to plan patient interactions, and direct involvement of specialists in primary care contacts, including behavioral health when feasible."[2]

Dr. Milstein goes on to describe the many difficulties encountered while implementing the IOCP project, including the lack of incentives, problems with recruiting patients, shortcomings of the existing electronic health record system, and limiting specialty care to the highest-performing specialists. Nonetheless, the results were impressive:

"Evaluation of results occurred . . . after 276 patients had both participated in the program for at least 12 months and could be matched based on health spending risk factors to a non-participating Boeing-insured patient in the predicted high-cost quintile. Functional status scores, HEDIS intermediate outcomes scores, depression scores, patients' experience of care scores, and employees' absenteeism scores improved compared to baseline. Compared to a matched control group of Boeing's enrollees in Puget Sound that did not receive their primary care from one of the three physician groups, unit price-standardized per capita spending dropped by an estimated 20%, primarily due to lower spending for ER visits and hospitalizations."[2]

What does patient engagement look like in Marin County? A good place to start is with the county's three main coordinated care organizations: Meritage Medical Network ACO, Kaiser Permanente, and Sutter Health.

Recently approved as a Medicare ACO, Meritage (formerly known as the

Marin-Sonoma IPA) is using a format relatively similar to the Seattle project. "We are starting with four high-risk conditions: diabetes, congestive heart failure, asthma and COPD," says Andrea Kmetz, RN, Meritage's director of care management. "We've hired four new RNs to assist with outreach to patients. We want to identify the patients early, educate them, and monitor them closely. We'll dedicate RN case managers to specific medical practices and place these case managers in the physician offices. The goal is to have the patients seen by the MD and the RN at the same time and have the patients see them as a trusted team."

Kmetz adds, "We've outlined a system with a lead physician in every practice. This lead will review care for any patient that is outside established goals identified through online evaluation of the patient's lab, pharmacy and hospital admission data. That MD will report to the ACO case management committee for further review."

What's the biggest obstacle? "Connecting with the primary care physicians in order to enroll patients," says Kmetz. What works? "Well, we have a great information system that lets us maintain the patient care plan, coordinate care with the physicians, and monitor the patients closely."

Cardiovascular disease (CVD) is the leading cause of death and disability in the United States. Dr. Dan Smith, a family physician at Kaiser San Rafael Medical Center, has been the local champion of the Kaiser PHASE program (Preventing Heart Attack and Stroke Every day) for the past four years; the program has been in existence for eight years. He explains that patients enter PHASE as part of secondary prevention for myocardial infarction, coronary artery disease, diabetes, peripheral vascular disease, or stroke, or if they are referred as a new patient by a primary care physician. The PHASE program assists with the management of 10,000 patients in Petaluma, Novato and San Rafael.

PHASE patients, according to Dr. Smith, are co-managed by specially trained pharmacist care managers. These pharmacists are in the doctor's office, working directly with the patient's doctor and the patient. A database allows the pharmacists to enroll all appropriate patients. The pharmacists develop customized care plans in coordination with the patient's physician. The pharmacists also outreach to patients to educate them about their chronic disease and teach them the skills needed to improve their health.

Patients' labs and tests are under regular review by their pharmacist care manager. Intervention occurs if the patient's LDL is greater than 99 mg/dL, blood pressure is greater than 139/89, or the hemoglobin A1c is greater than 6.9. The patient receives a phone call from the pharmacist to discuss their test results and next steps. Patients are reminded regularly of labs that are due or appointments with their care team. If patients are noncompliant or not engaging in their care, an escalating reminder system of robo-calls and letters is used, up to and including an outreach phone call from their primary care physician.

As Dr. Smith says, "The program works. It has lowered the likelihood of death due to heart disease by 30%. If you are a Northern California Kaiser member, your risk of dying from heart disease is lower than your risk of dying from cancer."

In contrast to Kaiser, Sutter Health is relatively new to the patient-engagement arena. Three Sutter affiliates, including the local Sutter Pacific Medical Foundation, have partnered with the Pacific Business Group on Health (PBGH) in an intensive outpatient care project. The project targets a high-risk chronic disease population with specialized education classes, patient visits, and close contact with the patient population. Patients are identified using predictive modeling software.

"This high-risk chronically ill population represents about five to eight percent of the total population," says Don Ransom, PhD, Sutter's local director of clinical integration. "We think the ratio is about 100 of these patients to one RN."

How to pay for all the extra nurses and support staff? "We're funding this project internally for now," says Dr. Ransom, "but the larger PBGH demonstration grant is intended to provide results that encourage CMS [Medicare] to modify its payment model for primary and population-based care. We have begun to make these kinds of structural changes in the way we provide care to keep people healthier and out of the hospital. As Sutter Health takes on increasing risk for the total health care dollar, these kinds of initiatives to reduce the total cost of care will make sense financially."

Money is a significant problem for these new patient-engagement programs. As Dr. Toni Brayer, chief medical officer of the Sutter West Bay region, points out, "Nobody's paying for this stuff!"

Starting up patient-engagement programs is expensive, and the payoff down the road is uncertain. "And we're at a disadvantage in Northern California", says Dr. Ransom. "We already have a low readmission rate to hospitals and, overall, provide Medicare services much more efficiently and at lower cost, in terms of the total cost per beneficiary per year, than the rest of the country. There may not be much excess money to squeeze out in the care of traditional Medicare patients."

Whether or not these programs will save enough money to pay for themselves is yet to be determined. Nonetheless, it's becoming clear that once patients understand they are being cared for by a team, they seem to like it. Some form of "hypermanagement" of chronically ill patients seems to be here to stay. ◇

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Patient Engagement in Diabetes Care

Kevin Kobalter, MD, and Arpita Pitroda, MD

The concept of patient engagement has been much discussed of late, particularly in the context of government imperatives to streamline healthcare delivery and reduce costs. Patient engagement means different things to different people, but a definition from the Center for Advancing Health seems to capture the essence: "We define engagement as actions individuals must take to obtain the greatest benefit from the health care services available to them."[1]

Achieving this goal requires emotional and intellectual involvement by patients in healthcare decisions and actions. They need to grasp the complexities of medical testing and the consequences of pharmacologic agents, and to possess the skills necessary for navigating digital medical records. They have to interact with providers not just in the office but also online, and to avail themselves of the considerable educational data linked to online medical care. All of this requires both computer hardware and computer literacy.

Diabetes care provides a particular set of challenges for patient engagement. The disease is disproportionally costly from a payor's standpoint: most data suggest that while diabetics represent only 7–8% of the population, their healthcare costs consume nearly 30% of dollars spent. Providers and insurers therefore have a vested interest in leveraging those aspects of patient engagement with diabetes that maximize benefit while limiting costs. Patients face similar issues with respect to their unreimbursed costs, not to mention the very real impact of diabetic complications.

Most medical conditions require some type of therapy and a mechanism for monitoring the success of that therapy. For conditions like hypertension or hyperlipidemia, simple measurements are usually made to assess the adequacy of daily pharmacologic therapy. The patient must comply with medication regimens and periodically visit the doctor or laboratory; but on a daily basis the time and effort are modest.

In contrast, diabetes provides a more complex landscape. Virtually every aspect of life impacts both short- and long-term success of diabetes treatment. Diet, exercise and drug therapy for the disease all interact in complex patterns. Absent careful attention to all these factors, both medical failure and severe consequences associated with hypoglycemia can arise. The full palate of diabetic complications need not be recited, but most are closely tied to long-term levels of glucose as measured by HbA1c. Myocardial infarction and stroke arise at much higher rates among diabetic patients, and these are tied to glucose control as well. For the patient, diabetes tends to be an overwhelming and challenging condition. It arises suddenly from the patient standpoint and dramatically alters their sense of well-being.

To maximize patient engagement with diabetes, various psychological, educational, institutional and financial barriers must be overcome. In our practice model at Kaiser San Rafael, we address the disease at many different levels. These include patient-centered issues like education and decision making, interaction with a digital record, and online access to providers and informational links. Our multidisciplinary team of providers also pursues diagnostic screening and outreach based on data mining of electronic medical records. This mining allows for identification of all diabetics in our facility and use of population management strategies through registries.

Oversight is performed by members of our healthcare team, which includes physicians, pharmacists, nurse practitioners and clerical support staff. Protocols for optimizing glucose control and preventive therapy for coronary disease, peripheral vascular disease and renal insufficiency can be broadly applied. Compliance is reinforced by phone or email contact.

From an institutional standpoint, patients whose records are computerized, who have access to their records, lab, and medications, and who actively participate with online communication are more likely to be invested in their well-being. They will have a greater

Dr. Kobalter and Dr. Pitroda are both endocrinologists at Kaiser San Rafael.

sense of control over their diabetes. The feedback and dialogue possible with online access to providers and medical records represent the best of the benefits offered by evolving healthcare data innovations. These innovations are necessary to realize the purported benefits of expensive digital records and online data.

At the level of the individual patient—the human being in our office—the problems are more complex. As noted above, the diabetic patient commonly faces a sudden diagnosis that confers both inconvenience as well as questions of longevity and health. The disease challenges the very foundations of most people's lives. At this more granular level, our approach is focused on the individual rather than being population-based.

For physicians to administer optimal care, they must understand their patients and their lives. They must also accurately assess which interventions are possible and most likely to succeed. In some instances this assessment will involve choosing the right medication. More commonly, it will involve understanding the how and why of patients' lives. The assessment also extends to age, comorbidities, intellectual capacity, long-term prognosis and many other complexities.

Connections on the individual level require time and thought. This extra effort is necessary because failure to provide such connections can result in suboptimal outcomes. For many years, the management paradigms for diabetes were extremely prescriptive. They ranged from specific therapies to frequency of testing and a rigid set of dietary recommendations. These recommendations were often bitterly debated among academics. The most frequent losers in those debates were patients who may have been provided with general dietary advice that was personally irrelevant or incorrect.

Thankfully, over the past two years, shifts in conventional thinking—and perhaps more importantly, organizational guidelines—have moved toward a more patient-centered care model. Specific therapies, diets and targets for glycemic control have given way to more broadly organized ideals with considerable room for individualization.[2] This shift represents a win for diabetic patients and their physicians, but it does encumber doctors with an obligation to educate and assess patients, and to make important therapeutic decisions that are not clearly defined in a simple guideline.

To ensure optimal outcomes, physicians not only need to grasp the intricacies of each individual patient, but also to assess whether the patient understands the disease and is adequately motivated. We find there are typically three types of people who suffer from diabetes. They live along a spectrum, and often our job is to move them from one part of the spectrum to another.

The first segment of the spectrum is best described as denial. These patients don't feel bad, don't acknowledge illness, and do little or nothing to address their diabetes. The second part of the spectrum consists of patients who understand they have an illness and that their illness has consequences. The *sine qua non* of this group is that they will tell you why they cannot: cannot exercise, cannot eat correctly, cannot reliably take their medication. Typically they attend visits but fail to achieve glycemic goals. The third portion of the spectrum is comprised of people who resemble those in the second, except instead of telling you why they cannot, they tell you how they will make the necessary changes to improve their diabetes. Often the most critical part of patient engagement lies here: investing the individual with responsibility for control of his or her disease.

The concept of patient engagement is varied and complex. It depends on whether one looks at the patient's perspective, the healthcare organization's perspective, or the payor's perspective. While all have a vested interest in maximal engagement and best outcomes, the fundamental elements of healthcare have not changed. Although computers, digital medical records, web-based education and 24-hour email access offer considerable opportunity, optimal care outcomes are still primarily dependent upon the patient and providers who have the time, interest and knowledge to inform and motivate their patients to take charge.

Even if patients develop the skills needed to successfully navigate the healthcare system, they can never be fully successful without expert caring. The challenge going forward will be in providing this essential element to our patients with diabetes, not to mention a myriad of other conditions. ◇

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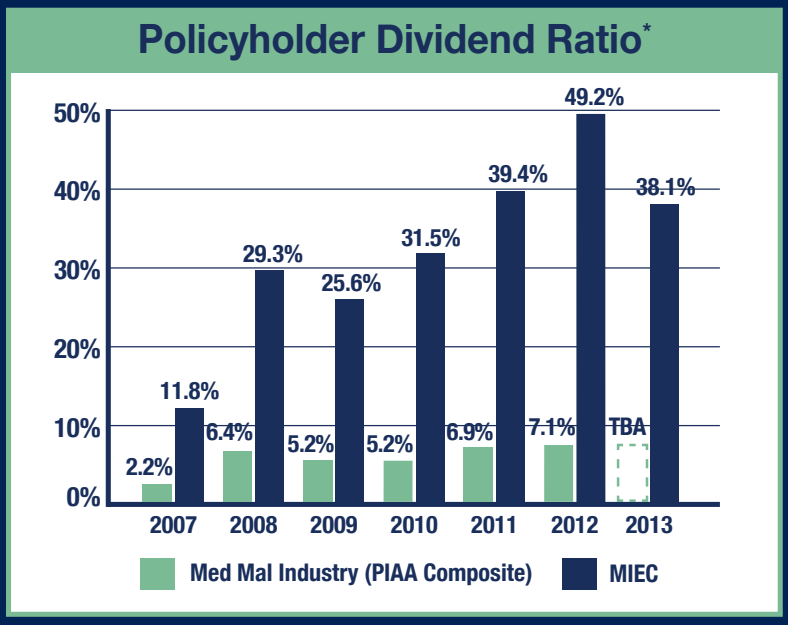

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Reducing Hospital Readmissions

Terry Winter, RN, MPH

Marin General Hospital (MGH) has launched a major initiative to improve the experience of patients and their families through better communication, earlier planning, and clearer guidance on what to expect after hospitalization. Any patient leaving the hospital deserves a safe, low-stress transition, but that hasn't always happened in the past. In fact, patients often haven't been given all the tools necessary for a safe discharge—a discharge that makes the need for future readmission less likely.

Our aim is to encourage better health outcomes and fewer readmissions. Although our readmission rates are similar to the national average, they're still too high. At MGH, 12% of our seniors are readmitted within 30 days, and 15% within 90 days. These figures don't even include the 10% who return to the emergency department for care.

While our technical care is thorough, we sometimes inadequately prepare patients for a healthy transition out of the hospital. Through interviews and focus groups with elderly patients recently hospitalized at MGH, we've learned that 75% were unable to verbalize important information about their diagnoses, medications, plan of care, or ways to prevent exacerbation or recurrence of their conditions. Nearly two-thirds were unclear about their follow-up appointments. Although patients often said they were given too little information in the hospital, they also admitted that they rarely asked for clarification. Whether or not we shared all this information with them during their hospitalizations, little was communicated in a manner that stuck. We need to change that.

To reduce readmissions, MGH has adopted two national, evidence-based models that address these communication gaps and have been shown to significantly reduce the risk of readmission.

The first is Project RED (Re-Engineering Discharge), a program developed by researchers at Boston Medical Center that focuses on changes in hospital practice to provide better tools for patients and caregivers. The essence of Project RED is creating more defined interdisciplinary teams for providing care; more effective, timely communication between all members of the team; more thorough engagement of patients and caregivers in their illness and treatments; and a better understanding of what to expect after discharge.

Project RED starts by setting a plan for discharge and outpatient follow-up as soon as the patient is hospitalized. The next step is to reconcile inpatient medications with home meds immediately. The outpatient follow-up is scheduled before discharge, including having a clear, executable plan worked out with the patient for tests and post-discharge treatment. The hospital also makes sure the patient knows which tests are still pending at discharge and with whom to follow up.

At all points in this process, the hospital focuses on improving how we communicate with patients and caregivers, from their diagnoses to what medications we are prescribing and why. We make sure patients and caregivers understand what symptoms are signs of complications that require immediate follow-up ("red flags") by requiring them to "teach back" what we've told them. The goal is to ensure comprehension.

An important element of Project RED is eliminating surprises. Patients need to know what to expect after discharge, and they need to know when and who to call if problems arise—including evenings or weekends. We hope to achieve this goal by providing clear, patient-friendly discharge instructions (due to be rolled out in May), and by initiating follow-up calls to patients a few days after discharge. During these calls, we check on their condition, review medications, reinforce the discharge plan and eliminate any barriers to its implementation.

The second model for reducing readmissions is Care Transitions Coaching—a program for seniors at higher risk because of age, limited support or their overall medical condition. This program replaces the follow-up phone call with the intervention of a specially trained, community-based Care Transitions Coach who meets with the patient or caregiver in both the hospital and the home and makes at least three follow-up calls within one month of discharge. These coaches engage patients to help improve their self-management skills, measure their understanding of their situation and needs, reinforce hospital discharge instructions, identify medication discrepancies, and solve problems.

Coaches also help patients create a Personal Health Record for articu-

Mr. Winter directs the Care Transitions Program at Marin General Hospital.

lating their needs and questions and keeping a running log of their health conditions, including "red flags" and medications. Patients are encouraged to use the record to write questions for their physicians, and to bring the record to all medical appointments as a reminder.

How are these improvements being implemented at MGH?

We have created a new seven-days-a-week pharmacy tech position dedicated to compiling an accurate home medication history that the physician can reconcile with the regimen ordered upon admission. Any potential confusion is clarified by calls to medical offices, outpatient pharmacies, and families or caregivers.

We're also debuting a mobile application called CareBook that allows the entire care team to communicate individually or collaborate in groups in real time during the hospitalization. MGH is the first hospital in the world to employ this innovative, cutting-edge tool.

All of the key communication elements of CareBook are now built into the hospital protocol, from immediate anticipation of a discharge date (this can be changed later if necessary); to development of a care plan; to working with the patient and caregiver to ensure they fully comprehend their diagnosis, treatment, medications, and post-hospitalization plan. Throughout hospitalization, nurses will assess the patients' level of comprehension in each of these areas to improve their understanding and ability to follow through after discharge. This continuous assessment eliminates a last-minute scramble at discharge, which can be confusing and incomplete for the patient.

Finally, we make sure that patients discharged from the medical or surgical units at MGH are followed-up by a supervising nurse (phone call 2–3 days after discharge) or a Care Transitions coach (hospital visit, home visit and phone calls).

As CareBook is more fully implemented, specialists and primary care physicians who choose to participate will be notified electronically of admissions or discharges of their patients. We're also working to make discharge instructions more comprehensive, patient-friendly and readable, and to allow all members of the care team to incorporate their recommendations into this document. These instructions will be accessible on the Web to patients and outpatient providers involved with CareBook. To allow for continual improvement, MGH will engage in extensive measurement to monitor the strengths and weaknesses of our interventions.

If you care for patients at MGH and would like to go live with CareBook, contact Terry Winter, director of the Care Transitions Program, at wintert@maringeneral.org, or Dr. Susan Cumming, medical director, at cumminss@maringeneral.org. You can also encourage your staff to provide priority access for your hospitalized patients when they call from the hospital for follow-up appointments. Scheduling follow-up appointments before the patient is discharged is critical to implementing a safe and successful transition.

Finally, you can reinforce the work done by Care Transitions coaches by addressing questions articulated by your patient in their Personal Health Record. It's important for them to see that their concerns are being heard. We can all provide safer transitions for patients by making strong communication and patient engagement a true priority. ◇

Email: wintert@maringeneral.org

Special thanks to the following funders and community partners for their support of Care Transitions coaching: Gordon and Betty Moore Foundation; Marin Community Foundation; Marin General Hospital Foundation; County of Marin Division of Aging and Adult Services; Meritage Medical Network; Seniors at Home/Jewish Family and Children's Services; Sutter Care at Home; West Marin Senior Services.

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Companions for At-Risk Pregnant Women

Maria Vierra

For many women living in Marin County, pregnancy and birth are a joyous time shared with partner, family and friends. But for many Latinas who are recent immigrants, pregnancy can be a time of uncertainty and apprehension. In the low-income, primarily Latino "Canal" neighborhood of east San Rafael, many expectant young mothers are new to the United States, speak limited English, and lack the support of family and friends left behind in their country of origin. Some have experienced domestic violence, social isolation, rape or other major trauma, either in their home country or locally. As a result, many of these women are depressed and anxious as they face the prospect of pregnancy and delivery alone in an unfamiliar country.

Canal Alliance—a nonprofit organization located in the Canal neighborhood that has been serving Marin's low-income Latino immigrant community for 30 years—began the *Compañeras* program several years ago to address the needs of at-risk pregnant Latinas. Based on the Latin American *Promotora* (promoter) model of using peer health educators/community health workers to reach out to people within their own communities, the *Compañeras* (companions) program connects bilingual, bicultural community volunteers with pregnant Latinas. The *compañeras* provide education and emotional support for a minimum of one month before the birth, during labor and delivery, and at least one month after the birth.

Recent research indicates that prolonged stress or trauma experienced by pregnant women can cause chemical changes in a fetus's body that can affect brain development and lead to behavioral or intellectual problems later on.[1] The goal of the *Compañeras* program is to reduce mothers' stress levels and increase their well-being so they are better able to bond with their infants and create a healthy environment for them. Infants in the program are more likely to be born healthy and to thrive.

Made up of two coordinators and a core of 6–8 active *compañeras,* the program serves approximately 50 women each year, many of whom are referred to the program by Marin Community Clinics after being identified as at-risk for depression or having a high-risk pregnancy. The *compañera* conducts prenatal and postpartum home visits to assess the safety and stability of the environment for mother and baby, provides emotional support, and in many cases accompanies the mother to the hospital delivery room to serve as both interpreter and coach during labor and delivery.

For many monolingual women, the experience of labor and delivery while being unable to communicate with hospital staff is particularly terrifying. Having the *compañera* present to interpret instructions and information from hospital staff and provide encouragement and support in the mother's own language is particularly important to relieving stress and improving the birth experience.

One tragic local story illustrates the importance of the *Compañeras* program in providing both practical and emotional support to monolingual parents. In this case, the unborn baby had been diagnosed with a chromosomal disorder and was not expected to live much past birth. The baby's parents, Miguel and Lety (not their real names), had known for some time that their child would not live, and they were grief-stricken as they waited for the baby to be born. Although a hospice counselor was present, the counselor did not speak Spanish.

Isabella (not her real name), the *com-*

Ms. Vierra is the grant manager for Canal Alliance.

pañera who attended the birth, interpreted for the couple and helped them make necessary arrangements for the baby's body. After the baby was born, Isabella stayed with Miguel and Lety at the hospital until their child died almost 20 hours later. Throughout this time, Isabella served as an intepreter between the couple and medical staff and ensured the couple had privacy. Later, she helped them make arrangements with a local funeral home, a task that would have been doubly hard for them since neither speaks English.

Isabella attended the funeral and burial to provide additional support. She remains in regular contact with the couple, who have expressed deep gratitude for her support, friendship and help in making a tragic event less traumatic.

In cases like this one, the experience can be nearly as intense for the attending *compañera* as for the delivering mother. To help cope with the emotional stress they sometimes experience, *compañera* volunteers check in regularly with each other to share their experiences and provide practical advice and peer support. Although tragedies do occur, most mothers and infants come through their birth experience healthy and ready to bond to each other. *Compañera* volunteers consistently express gratitude at being able to help mothers through the process and witness the mother's joy when the baby is placed into her arms. As a result of their shared experience, some *compañeras* and mothers develop friendships that continue over many years.

In addition to providing peer and labor support, the *Compañeras* program provides follow-up case management with all new mothers to ensure they are in a stable home situation, are aware of other services they can access—such as the Canal Alliance's food pantry, baby clothing and equipment, rental assistance, and support groups—and to ensure that they have made their "well baby" doctor's appointment.

The *Compañeras* program has been so successful that Canal Alliance recently launched a similar program in collaboration with Novato Youth Center and Bay Area Community Resources to train a core group of *promotoras* to provide peer health education and outreach in the areas of mental health and substance abuse prevention. Canal Alliance has also provided training for the *promotoras* to offer domestic violence prevention outreach. Through this innovative and highly effective *Promotoras* model, Canal Alliance hopes to improve the health of Canal residents and decrease the health disparities between the Canal neighborhood and other areas of Marin. ◇

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For more information about the Compañeras *program, contact Sandy Ponek at sandyp@canalalliance.org or 415-306-0422.*

Reference

1. Shonkoff JP, et al, "Neuroscience, molecular biology, and the childhood roots of health disparities," *JAMA*, 301:2252-59 (2009).

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Public Health Officer Matt Willis, MD, MPH

Erin Farahi

Dr. Matt Willis was named Public Health Officer for Marin County last November. A Marin native, he moved to the East Coast during high school and then spent four years on the U.S. National Cycling Team before entering Brown University, where he majored in medical anthropology. He received his MD from Temple University and his MPH from Harvard School of Public Health. After completing a residency in internal medicine at Cambridge Hospital, he spent six years in the U.S. Public Health Service, first with the Indian Health Service in Arizona and then at the CDC in Atlanta, where he worked as an epidemic intelligence service officer. He moved back to Marin in 2011 and took a job as an internist with Marin Community Clinics before joining the Department of Health and Human Services. He lives in San Anselmo with his psychiatrist wife Heather, their three children and a dog.

Ms. Farahi is a planner/evaluator for the Marin County Department of Health and Human Services.

What are your first impressions of your new job?

This is an exciting time in the health system nationally and in Marin. Health care reform is upon us, and having straddled the line between clinical medicine and public health throughout my career, I recognize opportunities for new alliances between frontline provider systems and public health advocates. I hope to be an effective bridge between these two worlds. In my first three months as Public Health Officer, a few questions have consistently arisen, and I'm honored for this opportunity to address the physicians in the Marin Medical Society and other readers of *Marin Medicine.*

What exactly is the role of the Public Health Officer?

One definition of public health is "the science of creating an environment in which all people can thrive," and that broad goal underlies all of my work. Specifically, most of my responsibilities as Public Health Officer fall into three domains: control of communicable diseases; disaster preparedness; and prevention of chronic preventable conditions. The history of the Public Health Officer connects to the turn of the last century, when the primary threats to public health were infectious diseases. Because there were no antibiotics or widespread vaccinations, the main tools of public health were isolation and quarantine of cases and promoting hygiene to control disease spread. My

early predecessors in Marin County were located at the quarantine station for immigrants on Angel Island.

Fortunately the role of the Public Health Officer has evolved significantly as social and medical science have advanced. While I carry the responsibility and authority to control the spread of communicable diseases in our population, this is only part of my job. The Public Health Officer also plays an integral role in preparedness for either natural or man-made disasters.

Today, however, the primary threats to public health are chronic diseases. The leading preventable causes of death are cardiovascular disease and cancer, both nationally and in Marin. Cardiovascular risk is especially tied to everyday decisions about nutrition and activity. So as Public Health Officer, it's also my role to help promote an environment in which every person has the opportunity to make healthy choices every day.

How do you set public health priorities, and what have emerged as top priorities?

As clinicians know, clinical decision making is based on a combination of diagnostic data and evidence, as well as individual patient goals. Public health decision making is similar. It is largely data-driven, while remaining responsive to community priorities.

An analysis of basic diagnostic data for Marin's health has helped clarify my goals as Public Health Officer. Marin is consistently ranked at the top in the state for county-wide health indicators. Marin's men have the longest life expectancy of any county in the nation. Marin is a wonderful place to understand the power of healthy eating and active living. We are known nationally for supporting small farms and locally grown produce, for protecting green space, and for valuing exercise and outdoor activity. We have among the lowest smoking rates in the nation.

That culture and those opportunities are some of the reasons my wife and I chose to move our family here last year. It is a public health priority to protect and spread those elements of our shared community that have such clear health benefits. However, Marin is also a good place to understand health disparities. Taking the data to the next level, and comparing areas within Marin, we find the average life expectancy in Marin's least healthy neighborhoods is 17 years shorter than it is in the healthiest neighborhoods. Early cardiovascular mortality is a strong driver of disparities in life expectancy in Marin.

As I consider my priorities as the Public Health Officer, this data provides another clear organizer for long-term effort. County leadership, both in the Department of Health and Human Services and the Board of Supervisors, is also aligned toward addressing these disparities. There's general consensus that how long one lives should not be based on one's zip code.

What is the future of the relationship between health care and public health in Marin?

I see a role for enhanced partnership between public health and clinical providers in each of the three main domains of my work outlined above. For the control of communicable diseases, vaccination is an ideal model of a clinical intervention that protects both individual and population health. However, Marin has some of the highest rates of personal belief exemptions from vaccinations nationally. Public health can support providers' vaccination efforts through effective public education and policies. This influenza season, our public health nurses targeted skilled nursing facilities—where residents are at increased risk of influenza mortality—to enhance internal capacity for staff vaccination based on evidence that SNF employees are historically undervaccinated.

In the arena of disaster preparedness, health care providers will be among the first responders, and health care facilities need to be prepared for surges in any large-scale emergency. Our department organizes regular trainings with providers and facilities, so that all know their role in disaster response, and to secure support for those roles. Marin is fortunate to have a robust volunteer-based Medical Reserve Corps with almost 400 members. Their readiness is an important source of reassurance for all Marin residents.

Finally, public health and health care providers must partner in the shared design of the emerging health system in this period of reform. While specific reforms are being debated, increased reliance on the public health principle of primary prevention will be necessary to any sustainable system. Ultimately, health disparities will be powerfully diminished by improved prevention among those currently underserved. The Affordable Care Act, the patient-centered medical home, and increasing pay-for-performance around screening and education reflect the expectation that primary care can serve the public health goals of population-based prevention.

The local response to health care reform is an ongoing and dynamic conversation, and groups like the Marin Medical Society play an important role in consolidating key messages on behalf of clinicians. I look forward to participating in these conversations, and I would like to invite any members of the Society to contact me with questions or suggestions for how I can best support your daily work as providers of health. ◇

Email: mwillis@marincounty.org

The Year THEY Tried To Kill Me

Salvatore Iaquinta, MD

Note: *The following excerpt is from Dr. Iaquinta's recently published book* The Year THEY Tried To Kill Me, *which chronicles his surgical internship at Highland Hospital in Oakland. The book is widely available in both paperback and e-book editions, and $1 from every book sold goes to Operation Access, a local nonprofit that coordinates donated surgical and specialty care for uninsured and underserved patients.*

Dr. Iaquinta's Highland Hospital ID card.

I was startled awake by my pager's beep. It was midnight but felt later, as it always does when you're awakened abruptly. I dialed the number without turning on the light in the call room. Maybe it's nothing, I thought hopefully, and I can go back to sleep.

"Hello, Sal?"

"Yep."

"This is Brad. Get down to the CT scanner. Now."

I started to speed-walk. Something lousy is going on when a fourth-year resident pages an intern.

When you graduate from medical school, only two people think you're a doctor: you and your mom. The title "intern" indicates that you know jack squat. I was only 30 days into my internship, so I fit the bill.

I was sure Brad, the chief trauma resident, didn't want me; he wanted my attending and needed me to call him. This was my first day of subspecialty service—urology, neurosurgery and otolaryngology rolled into one. We worked directly with attending surgeons; there were no residents to oversee us as we bumbled our way through patient care.

While jogging down the hallway to the CT scanner, I tried to think of what I knew about neurosurgical emergencies, but nothing came to mind. Not because I was tired, but because I had never seen a neurosurgical emergency.

The trauma team was huddled around the CT monitors like bar patrons watching the Super Bowl. A lone computer console controlled the scanner in the next room. Brad looked over his shoulder at me.

"Who's the neurosurgeon on call?"

"Blanchard."

"Okay, call him. We'll tell you what to say."

As I paged Dr. Blanchard, Brad presented the man in the scanner. He had been punched in the face at a local drinking establishment. It was a knockout. He had come to by the time the ambulance arrived, but on the way to the hospital he lost consciousness again—an ominous sign.

"Yeah, what's going on?" Blanchard answered. Whenever I heard his Texas twang, I imagined a tobacco-chewing cowboy in worn jeans and boots. In person, he looked like an effeminate Englishman, small and dressed like he was going on a picnic.

Brad flipped through the black and white images of the patient's head on the computer screen. He started feeding me the magic words for Blanchard, who was notorious for not coming in while on call.

"There's a 48-year-old man who was hit and lost consciousness, came to, and passed out again en route. His CT scan shows a large subdural on the left with ventricular effacement and a 2-centimeter midline shift. He's intubated and unresponsive." The magic words—*effacement, midline shift,* and *unresponsive*—essentially meant the guy's brain was being squished by the blood inside his skull.

"Take him down to the OR. Shave his head. Start the case. I'll be there in a minute." Blanchard hung up.

Start the case? Cut open the patient's skull? Did he know to whom he was talking? I was suddenly in a movie—the wrong movie. I was out of character. I was supposed to be the jester. I didn't

Dr. Iaquinta is an otolaryngologist at Kaiser San Rafael.

know the script. What was I doing here?

I hit "0" on the phone.

"Hello, operator 13," a woman answered.

"Can you tell me the pager number of the anesthesiologist on call?"

"There isn't one."

"What do you mean?"

"Nobody reported in today and all the people we've paged say they aren't on call."

I hung up. The trauma team was waiting for my instructions. I didn't have any. I told them, "There's no one on call for anesthesia."

Everyone stood dumbfounded until they remembered that they were talking to a naïf. There's always an anesthesiologist in-house. I hadn't been here long enough to know it.

The other trauma resident, the unshakeable Asian woman, took command. "You bring the patient downstairs, I'll find an anesthesiologist." She said it with such authority I almost replied, "Sir, yes, sir."

Everyone split except for a nurse, the respiratory therapist, and me. We wheeled the patient downstairs. He didn't look like he had been punched. He looked like an ordinary guy sleeping on a gurney, except for the endotracheal tube coming out of his mouth. The respiratory therapist squeezed the bag at the end of the tube to push some air into his lungs.

I grabbed a blue paper mask and hat as we sped down the hallway. We got the gurney into the OR and moved the patient onto the table. Kendra had done her job; the anesthesiologist was waiting for us.

I put on the mask and hat. The room was full of blue-hatted, blue-masked people with white gloves. An outsider might think we were decontaminating nuclear waste. The patient was lying naked on the bed, his dark skin a stark contrast to the room's sterile whites and blues. A nurse put compression stockings on his legs. Another nurse set up the instrument table.

The anesthesiologist hooked up her monitors and threw a blanket over the patient as Blanchard strutted in. He had the blue hat and mask, but his scrubs were magenta.

"Can't do a case without the films, Sal," he said.

"I'll get them." I ran off to the CT scanner. The films hadn't come out of the printer before we left, but that excuse wouldn't have mattered to Blanchard or any other attending.

When I came back, Blanchard was peeling open the patient's eyes. He asked for my flashlight. The pupils were fixed and dilated; no response to light.

"He's probably already dead, but let's go ahead anyway. Maybe we can salvage his organs," Blanchard said.

What? I thought we were going to save a life. If this is just about keeping organs viable, I might as well have stayed in bed. Aren't we supposed to believe he can still make it? Isn't that why we're doing everything at top speed? What if his family doesn't want his organs donated?

Blanchard went to scrub and I followed silently behind.

"What can I do to help?" I asked when we had returned to the patient's bedside.

"You can do the case," Dr. Blanchard said.

Nothing in his voice indicated he was kidding.

He drew a large, backward question mark on the shaved scalp. "Cut down to the skull on a 90 degree angle on this line."

"Knife," I called, and, unbelievably, the scrub tech put the knife in my hand. I was 25 years old and about to do a craniotomy. I provided traction on the skin with my left hand and inserted the knife. The first cut was like butter. I followed the smooth curve.

"Slow down, it's not a race."

But this guy is dying. He might already be brain dead.

When I was finished, Blanchard pulled at the large flap I'd made. It separated easily from the skull. Everything turned red; the scalp really bleeds. He undermined the skin surrounding the wound and called for the hemoclip.

"Just push in on the skin edge and click." When he pulled the trigger a little plastic clip, about 1/4-inch wide, shot forward and grabbed the skin edge, pinching the blood vessels closed. He handed me the hemoclip and away I went. Clip, clip, clip until the cartridge emptied, then a reload and more clipping. After about 20 clips, hemostasis was achieved.

"Great," he said as I finished. "Drill."

The drill was placed in his outstretched hand.

"See this? It turns at 7,000 rpm, so only put it on something you want it to go through. The pedal is by your foot." He looped the cord around my forearm and handed me the drill.

I was a little kid again, playing with Dad's power tools. But the stakes were much higher now.

He marked off the four corners where I was supposed to make holes. "As soon as you're through, stop. The goal is to not drill the brain."

This is all a dream. This is a game. It's all make-believe. We're just playing doctor.

I couldn't even see a body under all the drapes, just a square of skull with some blood. The only evidence of a live patient was the beeping of the anesthesiologist's heart monitor.

I hit the pedal and the drill whirled to life. It had its own mission: to skip across the smooth skull. But my determination to not mess up prevailed—that, and brute strength. The drill sank into the skull. Blanchard kept the drilling area wet with saline. I pulled up a few times to check my progress. I pulled up once more when the resistance changed. There was a clean, 3-millimeter-wide hole in the skull.

"You're doing great. Next hole."

This time I didn't pull up so often. After I'd made the other two holes, Blanchard called for the electric saw.

"If you angle it properly, it will cut through the skull like air; otherwise it's work."

He handed me the saw.

A saw in my inexperienced hand sounds risky, but it was one of the safer tools at my disposal. It has a guard that prevents it from going too deep.

"Connect the outsides of the holes."

Ho hum, just sawing the skull. I'm

sawing a human skull. I'm sawing a living human's skull!

"What type of work do you do?"

"I saw human skulls; live people only, of course."

"Really? That must require a lot of training."

"Well, I went to medical school for four years, but I don't remember any lectures about skull-sawing. In fact, I don't remember any neurosurgery lectures whatsoever."

"How do you know what you're doing?"

"See the guy next to me? He's my mentor. When he's quiet, I can assume I'm doing things correctly."

But I didn't think I was. My angle must have been off. My hand was getting sore from trying to cut out the square.

When I finished, Blanchard took a small pick and lifted the cut square of bone. It came right off.

"That's what I like about young skulls. They're so easy to open."

Hmm. I'd never had that thought.

The dura mater, a protective sheath just inside the skull—"dura" meaning *hard* and "mater" meaning *mother*—is the only thing separating us from the brain. Blanchard poked a small hole in it with a scalpel.

"Take the scissors and cut out a flap."

"Scissors," I called. The dura wasn't so tough. It felt like I was cutting an al dente mostaccioli noodle.

We folded back the flap. I couldn't see the brain through the dark red clot. Again I thought of food: It looked like cherry Jell-O.

"Be careful with that sucker. Hold it like this," Blanchard ordered. He showed me the proper grip.

"Never use full suction. It will suck up the clot and the brain with it."

I remembered reading that the human brain is the same color and consistency as vanilla custard. Fresh brains are nothing like the stage props I was used to.

We started sucking away the clot with a coffee-stirrer-sized vacuum. I was glad machines are available for that. We went through 1.5 centimeters of clot before we uncovered the brain's mysterious folds. I wished I could have taken a picture. There was something mesmerizing about the spider web of veins covering the pale yellow brain.

It's hard to accept that such an ambiguous-shaped organ has so many functions. The brain is nothing like the stomach. You can look at the stomach and say the food comes in here and goes out there; the muscles jostle food and the glands secrete digestive chemicals. Straightforward and logical. The brain is just a squishy blob. You can't look at a wrinkle and deduce that the area controls leg movements. It would be like looking at the grooves of a record and trying to figure out what sounds are encoded.

"Brain retractor," Blanchard called. "If you use this you can put your sucker right on top of it. Then you know you won't be sucking brain."

He slapped it into my hand. It was a flat paddle of metal, like a steel tongue depressor. I slowly slid it under a clot and sucked above it.

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"Go ahead, you don't have to be so gentle. It's soft. It's a brain retractor." He politely omitted the "duh."

I suddenly realized how quiet the room was. The anesthesiologist, scrub tech, scrub nurse, and neurosurgeon were watching me remove a clot from the brain.

"What are the chances of survival for a patient is in this condition?"

"About one in 500."

So you're saying there's a chance. I manipulated a huge chunk of the clot onto the retractor and lifted it out. Just below the patient's head was a plastic bag, the Brain Bag, used to catch the dripping blood. I dumped the clot into the Brain Bag. Of course, some missed and splattered on my shoe. My mom would have a fit if she found out I forgot to put on shoe covers.

Fresh blood poured from under the edge of the clot. I couldn't see the source. It kept bleeding and I kept sucking. Some dripped onto the floor, a bit more onto my shoes.

When I finished we flushed the brain with warm saline. The bleeding stopped.

"Let's get out of here before the brain swells too large," said Blanchard. If that happened we wouldn't be able to put the bone back. Someone had accidentally thrown away the saved bone from the last guy Dr. Blanchard couldn't close. Dr. Blanchard wasn't too happy about that. The patient, of course, couldn't have cared less.

He told me to sew the dura closed. After I did that with a baseball stitch, we put the chunk of skull back on. We attached little metal brackets to hold it in place.

Blanchard inserted a long probe through one of the drill holes into the dura and one of the ventricles of the brain. This allowed the extra cerebrospinal fluid to drain as intracranial pressure increased from the swelling.

To close the deep layer of skin, Blanchard used interrupted stitches and I tied them. We closed the outside layer with staples, which hold the skin together with greater strength than stitches. At least that's what they told me in eighth grade when I had to get the back of my head stapled shut. I thought the Frankenstein look was cool.

As soon as the patient was off the table and I had transferred him to the ICU, I found a cozy desk chair at the nurse's station and started writing the orders. I was in a daze. I had just finished a case that fourth-year neurosurgical residents would have waited in line to do. But it was 3:30 a.m. and I had to think hard to figure out what orders I needed. A neurosurgical patient requires a fair amount of attention. The nurses have to watch for anything that might indicate an increase in intracranial pressure.

I looked up to see a woman around 40, wearing a dark blue suit. It was an odd hour for business apparel. She spotted me amid the drab cabinets and counters of the nurses' station and approached me with eyes full of questions.

"Hello, I'm Dr. Iaquinta," I said as I stood up and offered her my hand.

"I'm his sister, Tanya. Are you the doctor who did the surgery?"

"I'm one of them." No way was I taking full responsibility. I needed Blanchard to fall back on, in absentia. No family wants to look at an unshaven 25-year-old and imagine he just performed brain surgery on their loved one.

"How long before he wakes up?"

"He might not. He had a very severe bleed inside his head."

"But it was only one punch."

She was waiting for me to answer.

"It caused bleeding inside his skull. The brain can't tolerate bleeding. It's like he suffered a stroke."

"They arrested the guy who punched him."

I didn't know what to say. The only thing I could think was that a single punch had probably made the guy a murderer.

"What's that tube going into his head?" she asked. She certainly was calm; maybe because she was tired.

"It's a shunt that allows fluid building up around the brain to drain." That part was easy to answer.

She left me to go into the room with her brother. I followed her for a couple of steps. He was covered up to his chin in white blankets. The endotracheal tube protruded from his mouth, attached by a hose to the respirator. A second tube came out the top of his head and was attached to a pressure monitor. His eyes were closed and his face was sweaty.

Her eyes had become glassy. "Why are you always getting into trouble?" Her voice wasn't so much sad as disappointed. Maybe she was the responsible sister and he was the goof-off brother. She moved closer to his bed. I backed up to the nurse's station to finish charting and give her some privacy.

Seconds later, I heard the decisive click of her heels as she left. I was surprised she didn't have more questions. Maybe it was too much for her. That was the moment I realized that my "most exciting case" was someone's dying brother. While his family had been worried about him, I was just excited to cut open his skull.

I was afraid that made me a creep.

Less than two hours remained before I had to do morning rounds. I returned to the call room and flopped onto the plastic mattress. I should have fallen asleep immediately, but my mind was racing.

I wondered how much of a creep I was. Blanchard had taught me how to do a craniotomy. He and I worked in a rigid world that follows a logical course. Tanya, on the other hand, lived in a world much more unpredictable and harder to fathom. I didn't wish anybody harm. When the injured person arrived, I wanted to put Humpty-Dumpty together again. Neither the family nor the attending cared that I was a lowly intern; they just expected me to do the job. And I had done the job, albeit awkwardly.

Maybe I'm not cast in the wrong movie after all. It's just early; there's plenty of time for character development.

I fell asleep and dreamt of sawing skulls. ◇

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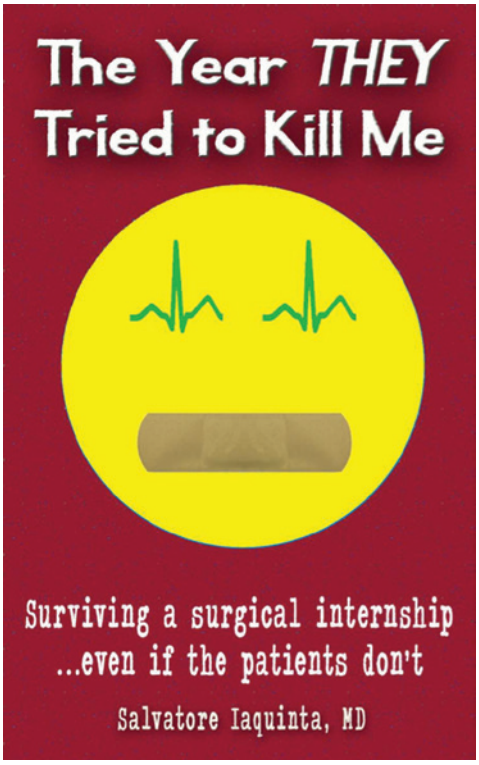
What Doesn't Kill You Makes You Stronger

Peter Bretan, MD, FACS

The Year THEY Tried To Kill Me, by Salvatore Iaquinta, MD, 352 pages, Purely Chaotic Publishing.



According to Dr. Salvatore Iaquinta, "Internship is the first year of residency. The surgical internship is the basis for the urban legends about doctors working 48 hours straight without sleep and then doing a ten-hour case on your mother."

In his book *The Year THEY Tried To Kill Me,* Iaquinta—who is now an otolaryngologist at Kaiser Permanente San Rafael—chronicles his surgical internship at Highland Hospital in Oakland from 2000 to 2001. His orientation begins with a pep talk from one of the chief residents: "If a surgeon tries to break you, don't. Remember that They are trying to break you. Let their insults roll off you like a bead of water. If you snap back once, it will haunt you. Nobody here forgets anything."

Iaquinta's book helped me relive my own surgical residency from 30 years ago, but this time I could laugh and smile about it because of the humorous self-deprecation he eloquently injects into the raw reality of universally intense, serious episodes of real-life surgical events. One need not be a physician or surgeon to enjoy his book. In fact, everyone can be thoroughly entertained by his true-life diary, in which he shares his experiences with circumspection and sensitivity, not typical of the public's perception of surgeons.

Many previous depictions of the surgical life—such as *The Making of a Surgeon, The House of God, MASH* and *ER*—are humorous as well, but this book demystifies surgeons and portrays them as human beings with emotions and frailties, just like their patients. Iaquinta shares his angst, anxiety, love, loneliness and eventual triumph, all against the backdrop of life and death in a busy county hospital which, as he typically understates, "can be a thankless place." I am particularly grateful for his dispelling of the typecast that all surgeons are cold steel, insensitive, callous, highly prepped technicians as a result of their grueling training.

Iaquinta answers the age-old question of why anyone would choose to endure such an intensely abusive year, followed by a career of taking on high-risk patients who suddenly require life-threatening operations and are often in need of vast emotional support. He answers simply, "I really want to cut people. In a legal, organized fashion, which is mutually beneficial to the cutter and the cuttee. Seriously. I'd die of boredom if I couldn't work with my hands." His answer is pure and from the heart. A surgical career is motivated by the individual satisfaction of expressing talent, training and art. The wonders of being able to perform life-saving surgeries are a reward unto themselves.

Iaquinta was born, raised and educated in Wisconsin. He devotes a chapter to the reasons for his cross-country odyssey to Highland Hospital, which was unlike anything he had ever done previously. The move was a stressor for him and his college girlfriend Rachel. Unfortunately, their long-distance relationship, which sus-

Dr. Bretan, a past president of MMS, is a urologist and transplant surgeon with offices in Novato and Sebastopol.

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tains him through his internship, also ends with it.

The most compelling chapter describes how Iaquinta uses his personal experience with the death of his father to empathize with a dying and comatose patient's family members and prepare them for her inevitable death. His sensitive interaction with the surviving family represents common aspects of the practice of surgery seldom known or appreciated by the public.

I called Iaquinta recently and asked him to describe the process of writing his book. He said it started with an email to a friend describing the first day of orientation. His friend replied, "Don't stop writing, it's priceless." He didn't. By the end of his "near fatal" internship, the diary was about twice as long as the final book. He spent several years honing the manuscript and emerged with a must-read for anyone who wishes to share one of the most intense years of training in any profession.

The book's characters are real, but most names are changed. One notable exception is Dr. Organ (now deceased), Highland Hospital's pioneering chief of surgery, renowned not just in the Bay Area, but throughout the world. Organ questions Iaquinta's decision to specialize in otolaryngology by asking, "Are you sure you want to be a nose picker the rest of your life?" Another memorable character is Corey, a chief surgical resident who is even-keeled and fair. Iaquinta reflects that, "Dr. Organ can be King of the Hospital for the rest of his life, but it will be Corey that I respect for throwing that extra stitch into the dude with the perforated ulcer."

In an epilogue, Iaquinta writes, "Despite being a big, smart doctor, I still can't believe people let me cut them, even if it is in a mutually beneficial manner." His book has received high acclaim since its release late last year. I thank him for his percipient record keeping of the special lessons of his surgical internship, as they are special for all of us. His work helps honor and elucidate the art of surgery. ◇

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Medical Advances of the American Civil War

Nitin Sil, MD

The American Civil War has always been recognized by historians for its watershed effect on social and military evolution. History, however, has been less than kind with its perception of the era's medicine. Images of amputation without anesthesia and surgery without respect to germ theory come readily to mind. Yet in reality the conduct of the Civil War had a profound effect on the art of medicine.

More than 600,000 Americans died during the Civil War—more than every other war the country has fought before or since, combined. At the beginning of the war, a strained and outdated medical system was ill prepared for and quickly inundated by a seemingly endless stream of wounded. Over the war's four long years, old ways were abandoned. Advances in procedures and medical doctrine rivaled advances in clinical thought. These advances combined to reshape the medical community. From this devastation arose what we perceive today as the foundation of modern medicine.

On April 13, 1861, the bombardment of Fort Sumter by Southern forces sent both sides into a frenzy of enlistment. Yet despite the patriotic fervor, the medical system lay practically dormant. Most doctors of that time were rural family practitioners who did not need a state medical license or board certification. In many cases, their medical education was limited to one year of study with no formal residency or didactic learning. Teaching hospitals were nearly a nonentity, and even the Surgeon General, Dr. Thomas Lawson, considered medical books an "unnecessary extravagance."

Dr. Sil is a hospitalist at Kaiser San Rafael.

Most medical dogma was rooted in the teachings of antiquity. Sickness was often felt to be based on humoral imbalances, and bloodletting was still one of the primary methods of treatment. Even surgery was considered taboo and rarely attempted. Boston's Massachusetts General Hospital recorded on average 39 surgical procedures annually between 1836 and 1846. Ambulances and mass medical evacuation systems had not been organized or even considered. Germ theory was still 20 years in the future, and as thousands of men organized into base camps for war, no vaccination or sanitation systems were employed.

As naive and unprepared as medicine was, its state of readiness only paralleled the state of military tactics. In July of 1861, a horrified nation learned of the death toll at the First Battle of Bull Run. Almost 3,000 soldiers gave their lives to inept and outdated methods of leadership based on tactics of the Napoleonic Era.

The death toll at Bull Run was soon overshadowed by nearly every other major engagement, as military tactics lagged behind advances in weaponry. At the Battle of Fredericksburg in December 1862, 18,000 soldiers were killed, due in part to advances in the rifled musket that greatly extended its killing range. At the Battle of Antietam, earlier that year, more than 22,000 died in a single day—Sept. 17—largely due to the development of the Minie ball. This conical .63 caliber projectile was relatively quick to reload and on impact could shatter vast tracts of bone and tissue. A major culmination of the war's destruction occurred at the Battle of Gettysburg on the first three days of July 1863. When the carnage was over, more than 50,000 soldiers were dead.

The rise in casualties was soon matched by medical innovation. By the second year of the war, both sides had initiated calls for medical reform. Physicians were required to pass board examinations, and standards of practice were introduced. Recruitment camps were required to begin vaccination protocols, and soldiers were rejected on the basis of physical illness. Doctors were given the ability to hold military rank and could allocate orders to assist in the retrieval and care of patients stranded on the battlefield. In certain cases, these orders could supersede those of their officer peers. This innovation was further expanded when Dr. Hunter Holmes McGuire, a Confederate field surgeon, championed the idea that medical personnel were to be treated as noncombatants. His concept was later ratified by the Union Army and was soon integrated into the foundations of what would become the Geneva Convention.

As Northern troops began to occupy the cities of the South, new methods

Carver Hospital, Washington, DC, ca. 1863. *Photo by Matthew Brady.*

of sanitation were introduced. When General Ben Butler assumed the command of occupied New Orleans in April 1862, he set up field hospitals, began a refuse disposal system, and vigorously employed the newly discovered drug, quinine. As a result, the years of Union occupation in New Orleans brought significantly lower levels of yellow fever and malaria.

These changes in sanitation and treatment were paralleled by better systems of medical logistics. An ambitious hospital building program began, and by 1863, more than 400,000 medical beds were available. Facilities that specialized in various types of surgery and rehabilitation were constructed. Inspection systems were developed and then used to maintain standards of care. As a result, hospitals saw a mortality rate of less than 10%. Trains were formed with hospital cars that could accommodate the transfer of patients. Early horse-drawn ambulances were constructed with suspension systems for more secure transport, along with on-board medical kits to treat soldiers in the field. Ships that had been initially used for military cargo were refitted to hold the wounded. By 1863, vessels were designed from the keel up with operating rooms and isolation wards, and were staffed by nautical doctors and nurses.

Surgery also experienced a renaissance. As the number of wounded increased, doctors had to create more efficient surgical methods. They devised new saws and chain devices, and they refined operating rooms, scalpels and instruments. By 1864, several subspecialties of surgery had emerged, including plastic, orthopedic, abdominal, thoracic, ocular and even neurological. For the first time, blood transfusions became ubiquitous, and prosthetic parts were created on a grand scale. Contrary to popular media, anesthesia was used and documented in over 80,000 surgeries. Medical literature even recorded the comparison trials of different types of anesthesia. Compared to their 1861 counterparts, surgeons in 1865 had gained unprecedented advantages in medical knowledge, experience and treatment options.

Two percent of the population of the United States died during the Civil War; two-thirds died from disease rather than battlefield injuries. While initially unprepared, the medical system was able to adapt over a period of four years. By war's end in 1865, newly built hospitals continued to provide services to thousands of wounded. The wartime innovations of hospital ships, ambulances and hospital trains continued to develop. Perhaps most importantly, medical professionals began to appreciate and expand on their wartime education. Medical dogma that had previously restrained advancement was questioned, and the need to discover, refine and evolve became the new paradigm. ◇

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A Good Year at Marin General Hospital

Joel Sklar, MD

Note: *Each issue of* Marin Medicine *includes a self-reported update from one local hospital or clinic, on a rotating basis.*

For Marin General Hospital (MGH), 2012 was a year of accomplishments on virtually every front, from making sizable planning strides toward a new, state-of-the-art, seismically sound hospital, to implementing new health programs and augmenting our network of clinics. We also completed a much-needed upgrade of our Emergency Department and received extraordinary community support, as well as recognition from numerous specialty medical organizations. All told, 2012 affirmed MGH as a critical, important part of the Marin community.

A few important milestones from the past year are reviewed below.

Awards and Certifications

We received recertification from the Joint Commission for our stroke program and also won a Gold Plus "Get With The Guidelines" quality achievement award from the American Heart Association and the American Stroke Association for the second year in a row.

Dr. Sklar, a Larkspur cardiologist, is chief medical officer for Marin General Hospital.

The American College of Surgeons reverified our trauma program, recognizing that our trauma center has all the capabilities listed in *Resources for Optimal Care of the Injured Patient*, and confirming our dedication to providing optimal care for these patients. In addition, Marin County approved a new 10-year trauma contract with MGH, which houses the county's only designated trauma center. The partnership with Marin County Emergency Medical Services means MGH will continue to provide trauma care for the entire county and to maintain a team of board-certified emergency physicians, experienced emergency nurses and other specially trained staff who are available 24 hours a day, seven days a week.

The American College of Radiology accredited our Breast Imaging Center based on our adherence to high practice standards in image quality, personnel qualifications, facility and equipment, and quality control and assurance procedures. To maintain their designation, facilities must undergo an onsite review every three years. Meanwhile, our Marin Cancer Institute became one of only 106 cancer centers nationwide (out of about 3,000) to receive an Outstanding Achievement Award from the American College of Surgeons. The award recognizes that we achieved a perfect score in all eight areas of measurement during our 2011 accreditation.

A consumer organization rated MGH as one of the safest hospitals in California. The organization's scoring focused on six categories: infections, readmissions, communication, CT scanning, complications and mortality. MGH received the top score possible on measures of infections and the hospital's use of scanning. In another high score, the Leapfrog Group gave MGH an "A" for hospital safety. This independent national nonprofit calculated our grade based on 26 measures, using publicly available data on patient injuries, medical and medication errors, and infections.

Our physicians received awards as well. More than 200 doctors practicing at MGH were named to the prestigious [415] Top Doctors 2012 by *Marin* magazine. The list was compiled through peer-to-peer polling of more than 4,000 doctors in San Francisco and Marin counties, with the results clearly demonstrating respect and appreciation for the excellent physicians at MGH.

New Facilities and Upgrades

Just 18 months after a $2.89 million donation jump-started the expansion and upgrade project for our Emergency Department, the completed project is delivering family-friendly waiting ar-

Braden Diabetes Center at Marin General Hospital.

eas, shorter wait times, and faster, more efficient assessment and treatment of the approximately 200 patients who visit the ED on an average day.

Nearby, a generous gift enabled the opening of the Braden Diabetes Center under the leadership of Dr. Linda Gaudiani. This leading-edge outpatient education and training program is intended to bridge a major gap in the care of patients with diabetes. The Center provides educational resources and collaborates with primary care physicians to significantly reduce complications and readmissions. The focus is on teaching self-management skills to patients and their families, including dietary and nutritional therapy and patient-friendly self-monitoring technologies.

MGH also acquired the well-respected Ross Valley Pharmacy Diabetes Self-Management Program and is expanding upon their offerings. This intensive course, certified by the American Diabetes Association, is designed to teach diabetic patients how to incorporate appropriate exercise, nutrition and calorie management into their daily living.

Next door to MGH, the Marin Healthcare District's Sirona Vascular Center opened a second location. Specialized vascular care provided by Dr. Laura Pak and her team will meet a growing need in the county's aging population. A full range of noninvasive testing of arterial and venous disease is offered. Areas of particular interest include open and interventional therapies for aortic aneurysm repair, minimally invasive procedures for deep venous thrombosis peripheral arterial disease, varicose vein treatments, limb salvage treatment for extremity trauma and gangrene, dialysis access surgery, and carotid surgery. The Center also offers the Venefit procedure for superficial venous reflux disease.

Sutter Arbitration

Following months of deliberation, the arbitrator in the long-running dispute between MGH and Sutter Health awarded the hospital $21.5 million. The arbitrator subsequently declared MGH the "prevailing party" and recently awarded the hospital an additional $11 million for attorneys' fees and pre-judgment interest. We believe the arbitrator's decision is the final chapter of this lengthy dispute.

A community hospital is only as good as the physicians and staff who practice there. We thank you for helping make 2012 a banner year. ◇

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In Honor of Dr. Michael Sexton

Irina deFischer, MD, and Peter Bretan, MD

Note: *Dr. Michael Sexton, a past president of both the Marin Medical Society (MMS) and the California Medical Association (CMA), recently retired after nearly 40 years as an emergency physician at Kaiser San Rafael. Both MMS President Dr. Irina deFischer and Past President Dr. Peter Bretan submitted articles honoring Dr. Sexton's distinguished career.*

Dr. Irina deFischer

I sat down with Dr. Michael Sexton on Feb. 18 to reflect on his career.

After graduating from the University of Iowa Medical School, Michael came to San Francisco for a rotating internship, initially intending to pursue a career in cardiothoracic surgery. Instead he took a position in the fledgling 5-bed emergency department at the old Kaiser San Rafael hospital. He became board certified through the practice pathway a few years later.

When Dr. Donald Trunkey published his report criticizing the outcomes of trauma care in community emergency departments in the early 1980s, Michael joined a committee formed of ER physicians and surgeons from all four Marin hospitals to review trauma deaths in the county. They were able to refute Trunkey's findings. This collaboration led Michael to serve on the MMS board of directors, where he headed the Violence Prevention Committee, working with other county agencies.

Michael's work with paramedics in his capacity as medical director of the San Rafael Fire Department led him to promote the pre-hospital DNR form, which was adopted statewide. He served as MMS president from 1993 to 1994 and represented Marin County as a delegate to the CMA House of Delegates until his election to the CMA board of directors in 1995. He served as president of CMA from 2005 to 2006.

During his time at CMA, Michael was able to bring his perspective as a group-practice physician to the discussion on HMOs, and he worked to create a culture in CMA where physicians could overcome their differences and work together to advance the medical profession. He believes that CMA's most outstanding accomplishment during his career was its successful prosecution of the RICO lawsuit, ensuring that physicians were paid fairly, on time, and according to the terms of their contracts.

As a member of the CMA leadership team, Michael began attending AMA meetings and joined the AMA's Group Practice Advisory Committee and the Organized Medical Staff Section. He became an AMA delegate in 2005 and was appointed to the AMA Council on Legislation the following year.

Michael has two grown children. Ryan, a paramedic, lives in Nashville with his wife, a doctoral candidate in biomedical research. Tessa is a first-year osteopathic medical student at Michigan State. Michael is looking forward to joining her in a medical mission in the Peruvian Amazon next August.

Asked for words of advice for his colleagues, Michael recommends focusing on what an honor it is for us as physicians to have patients put their lives in our hands, and to have fun practicing medicine.

Dr. Peter Bretan

Dr. Michael Sexton is not just a fellow Marin physician, but also a fellow Novatan. I met him during my first rotation as an MMS board member in 2000. I remember he returned as an emeritus guest at a contentious board meeting. The designation of a higher-level trauma center for Marin General Hospital was under discussion, and there were debates between Marin General and Kaiser board members. I vividly recall that Michael stayed neutral and helped guide us through a fair discussion. Since then I have always looked to him as leader and mentor.

As president of CMA from 2005 to 2006, Michael worked tirelessly and

Dr. deFischer is president of MMS, and Dr. Bretan is the immediate past president.

GUEST COMMENTARY

CAFP Strategic Plan

The 8,000-member California Academy of Family Physicians (CAFP) has set its course for the coming three years with an emphasis on three areas: 1) ensuring an adequate supply of family medicine physicians and other primary care physicians and health professionals to care for the anticipated increase in insured patients when health care reform provisions are fully implemented in 2014; 2) helping family medicine physician practices provide the most effective and efficient care possible through transformation to the Patient Centered Medical Home model of physician-led, team-based collaborative care (this will require ensuring appropriate payment for these enhanced patient services); and 3) supporting the above efforts with appropriate advocacy resources to achieve success.

As it does every three years, CAFP engaged in a strategic planning process based on environmental scans, literature searches, best-practices information, and the expertise of our board members, committee chairs and staff. Our 1.5 day retreat in July 2012 identified desirable goals along 3-, 5- and 10-year timelines; set priorities among those goals in our key areas of workforce, practice transformation and advocacy; and then fleshed out the top five vote-getters in each area for the next three years. Our staff then developed action plans to help us achieve those goals. The board of directors approved the plans late last year, along with the resources to start the process of achieving the goals in 2013.

In the workforce category, we will work to: 1) ensure a family physician is on every medical school admissions committee in the state; 2) ensure every residency director, FP faculty member and FP resident in California is a member of CAFP; 3) identify barriers to happiness/satisfaction of active family physicians and address those barriers to create a happier and more satisfied family physician workforce; and 4) increase interest in family medicine by 15% and ensure that the pipeline is filled with the best and the brightest medical students.

In the practice transformation category, we will; 1) create a virtual Patient Centered Medical Home University to warehouse PCMH information and CME programming about PCMH for our members' use; 2) establish coaching services and resources for family physicians transitioning to the PCMH model; and 3) advocate for payment reform to support transformation, which is a crucial component to adoption of this model of care.

Finally, in advocacy, we will: 1) identify barriers to our members' engagement in advocacy and create a plan to address them; 2) increase contact and engagement of family medicine residency programs in advocacy efforts; and 3) actively engage our membership with CAFP advocacy activities through social media. Ultimately, we see the need to encourage our members to establish and develop advocacy relationships at the local level—local officials become state and often national officials. We must find and sustain a method for increasing contributions to our political action committee, FP PAC, develop a mentor system to nurture colleagues interested in the legislative process, and ensure that every state legislator knows and relies on at least one family physician for legislative input on health issues.

In all likelihood, our goals for family medicine aren't that different from goals of our fellow physicians in other specialties. We welcome the opportunity to work with all through our medical society and specialty societies to improve care for our patients and find practice satisfaction for all physicians. ◇

spent almost 40% of the year traveling to Washington, DC, to represent the interests of both the medical profession and their patients. Despite his busy schedule, he was elected as District X's AMA delegate, a position he continues to hold. I later became an alternate delegate to the AMA and have benefited greatly from Michael's example and guidance during the semi-annual AMA meetings. He has always been a respected voice in both the California caucus and nationally.

While Michael and I don't agree on all issues, we have always agreed that physicians must find a united voice in order to have any chance of being heard by our legislators in determining healthcare policies. I am grateful for his tutelage and mentorship in organized medicine, and for his work ethic. I congratulate him on an incredible career as a physician leader, but most importantly I thank him for his friendship. ◇

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Michael Chase, MD, Internal Medicine*, 2 Bon Air Rd. #150, Larkspur 94939, New York Med Coll 1972

Matthew Willis, MD, Internal Medicine*, 899 Northgate Dr. #104, San Rafael 94903, Temple Univ 2001

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CMA Sets Agenda for 2013

California Medical Association

For more than 150 years, the California Medical Association (CMA) has fought on the frontlines of nearly every major policy, political, budgetary, societal and legal campaign affecting the state's physicians. The shared challenges facing physicians are more formidable today than ever.

As California and the rest of the nation faces a time of unique budgetary challenges and monumental change in health care, it is more critical than ever before that physicians come together with a unified voice to advocate for the profession and for the health and well-being of the patients we serve.

In January 2013, the CMA Board of Trustees adopted five distinct goals for the association this year. Below are details of each of those goals.

Grow Membership by 5%

CMA member physicians are our most valuable asset. Without your dues dollars, CMA wouldn't be able to do its vital work protecting the practice of medicine and ensuring access to quality medical care for all Californians.

Over the past two decades, organized medicine nationwide has seen a gradual decline in membership, and CMA was no different. In 2011 and 2012, however, we reversed that trend, reaching a 20-year membership high of more than 37,000 members last year.

CMA made a significant investment in membership development in 2012, increasing data analysis and ramping up recruitment and retention efforts. These efforts, along with focused recruitment achievements in select counties, resulted in a net growth of over 2% for the year. It may not sound like a lot, but after years of slow decline, 2% growth is a significant and laudable achievement.

Our goal for 2013 is to continue the forward momentum and grow membership by 5% by year's end. Increased recruitment activities in 2013 will focus on "pilot projects" with select partner counties.

Commitment to Public Health

CMA has a rich history and legacy of demonstrating its commitment to public health. CMA has incorporated key public health legislation in its legislative agenda every session and has maintained a high profile on public health issues. Advancing reforms in order to benefit our patients and the public has always been a priority for the association, and continues to be at the top of our list.

In 2013, CMA will be working proactively with public health leaders to track emerging trends and to strategize solutions for continuing challenges.

We will continue to include legislation focusing on public health in the legislative agenda this year. CMA is also exploring new ways of demonstrating its commitment to public health, including providing educational briefings to legislators on public health matters and participating in health fair-type events.

Prosperity for All Physicians

At no time perhaps since the creation of Medicare has the health care delivery system seen such dramatic and rapid changes. The transformation of health care in California is largely being driven by three major developments:

- The rise of large medical groups, integrated delivery systems and advanced analytics, health information technology and population health management.
- Health care reform-related policy changes at the federal and state levels that emphasize care coordination, accountability and paying for "value"—efficient, high quality care.
- Purchasers—private insurers in California and the nascent Covered California Health Benefit Exchange—are making it very clear that physicians and hospitals need to control costs or risk being isolated or frozen out of increasingly narrower network products.

These trends will likely accelerate as cost pressures grow, and health reform and other private sector initiatives continue to ramp up in 2013 and beyond. These powerful forces pose particular challenges and opportunities for independent physicians and medical groups interested in maintaining a degree of autonomy while market and policy forces are driving the industry towards hospital-led systems. At the end of the day, the system benefits from a diverse set of providers competing to deliver high-quality, high-value care.

Over the next year, CMA will be working feverishly to help physicians in all modes of practice to not only thrive in the rapidly changing health care marketplace, but to lead the charge towards new patient-centric, physician-led models of care.

One of the biggest challenges for physicians now and in the future is access to capital to invest in their own practices so that they can expand into different markets, adopt new technologies and care models, and maximize reimbursement. Without capital for necessary infrastructure, physicians are unable to implement systems to help them remain competitive and independent. In contrast, hospital systems and health plans are at a strategic advantage.

CMA staff are developing three distinct proposals that represent "game-changing" strategies in support of prosperity for all physicians: 1) Study and design physician-led health care delivery models and create a CMA-sponsored backbone for independent physicians and medical groups; 2) Develop and implement a quality initiative for independent practices with the goal of reducing clinical variation; and 3) Increase physician access to financial capital.

Stay tuned for additional details as these proposed initiatives evolve over the coming months.

Defend MICRA

The trial attorneys have sought to modify or eliminate California's Medical Injury Compensation Reform Act (MICRA) protections since the state's landmark medical malpractice insurance reforms were established in 1975.

Under MICRA, injured patients are fairly compensated, medical liability rates are kept in check, and physicians and clinics can remain in practice treating patients. MICRA has no limits on the economic damages (medical costs and lost wages) that can be recovered by injured patients. Injured patients also can sue for unlimited punitive damages and recover up to $250,000 in non-economic damages (pain and suffering). In addition, MICRA includes a sliding pay scale, which ensures that more money goes to patients, not lawyers. The $250,000 cap on non-economic damages has proven to be an effective way of limiting meritless lawsuits, but the cap has been targeted by the trial lawyers because it restricts the amount of money they can collect in damage awards.

For more than 40 years, CMA has defended this important law in the legislature, in the courts and in the court of public opinion. We have been successful primarily due to vigilance and allocation of sufficient resources on all fronts. This year will be no different.

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Several factors make 2013 a decisive year for defending MICRA. Both houses of the legislature contain Democratic super-majorities, traditional allies of the trial attorneys. Also, nearly half of the members of the Assembly are newly elected without a voting history. Attorneys are utilizing new and creative arguments to challenge long-standing constitutional approval of MICRA and to move public opinion. They are attempting to use heart-wrenching horror stories placed with compliant media outlets in order to defeat MICRA.

CMA in 2013 will focus on educating new members of the Legislature on the importance of MICRA for their constituents and the role MICRA plays in patient protection and access to care. CMA's government relations team will also be ready to jump into action at a moment's notice should the trial attorneys try and utilize a late "gut and amend" to push an anti-MICRA bill through the Legislature, as they did at the end of last session.

As always, CMA's political action committee (CALPAC) will remain involved in the fight, amassing the financial resources that will be needed should a costly MICRA challenge emerge this session. CMA's legal team also continues to aggressively monitor court activity and seek out opportunities to provide guidance to courts when they are asked by plaintiff attorneys to weaken or eliminate MICRA.

Lead Change in Health Care Reform

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA), which reformed the for-profit health insurance industry and beginning in 2014 will provide health insurance to most of the nation's uninsured. The ACA also formed the CMS Innovation Center to fund myriad pilot programs to test new health care delivery and payment models.

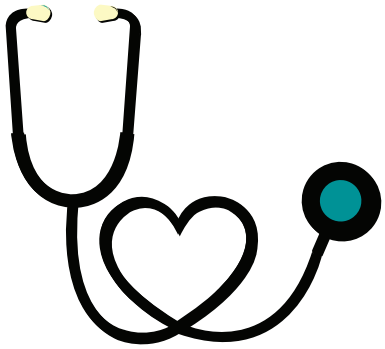
Under the ACA, two-thirds of California's uninsured will be covered by private insurance through a health insurance exchange purchasing pool. The remaining uninsured will be covered through a massive expansion of the Medicaid program.

CMA in 2013 will continue to monitor implementation of the ACA in California, ensuring that health care reform works for physicians and their patients. Specifically, CMA will remain engaged as Covered California, the state's health benefit exchange, prepares to open for business. The exchange's goal is to start pre-enrollment in October 2013. Critical federal regulations and guidance, however, still must be finalized and released.

Among the critical issues still needing to be hammered out before the exchange opens for business are: the state's plan for monitoring and enforcing network adequacy requirements; the reconciliation of major discrepancies between state and federal grace-period guidelines for premium nonpayment; and how exchange plans will handle the subject of out-of-network benefits.

While the pre-enrollment date is only months away, exchange leadership has yet to select which plans will offer products on the new marketplace, meaning that benefit design, contracting and enrollment policies will need to be developed at a breakneck pace.

CMA will also be working to make sure that physicians understand the implication of contracting with exchange plans and to ensure that doing so places minimal administrative burdens on physicians.



Together We Are Stronger

The shared challenges facing those who practice medicine may never have been more formidable than today. In this uniquely turbulent political and fiscal environment, we have redoubled our efforts to provide the support and services physicians need to be able to focus on their jobs and bring good health and happiness to the lives of millions of Californians.

Changes are coming—and CMA is poised and ready to meet the demands of the future. ◇

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The State of the Marin Medical Society

Irina deFischer, MD

I have been involved with the Marin Medical Society for close to 25 years, and during that time I have seen a number of changes. In my first term as president in the mid-90s, we had multiple active committees that reported to the board of directors at its monthly meetings, along with several well-attended social events, including the holiday dinner-dance at the Meadow Club, the spring wine-and-cheese at the Art and Garden Center, and the annual membership dinner at the yacht club. Over the years, attendance at these events began to dwindle, and some of them had to be cancelled. Is it that younger physicians just aren't "joiners," or that we've all gotten too busy to spend our precious free time with our colleagues? Or is it that our membership has become divided, and that we feel we have little in common?

I am a strong believer that county medical societies, along with the California Medical Association, have the potential to bring together physicians of all specialties and practice modes to advocate for the good of our patients and the profession, in ways that no single specialty society or other physician group can. When we bring physicians together, we're able to speak in a unified voice, and the more members we have, the greater our credibility. We're apt to find that there are more similarities between us than differences, and we benefit from listening to our colleagues' stories and concerns.

Dr. deFischer, a family physician at Kaiser Petaluma, is president of MMS.

When our past executive director, Roger Brown, retired six years ago, it was financially impossible to hire a full-time replacement for him, so the MMS Board signed an agreement to share Cynthia Melody's administrative services with the Sonoma County Medical Association and the Mendocino-Lake County Medical Society. The MMS office, which had moved from Larkspur to Corte Madera under Roger's tenure, became a virtual office, staffed by the shared employees in Santa Rosa. The financial savings enabled us to continue the Marin Medical Society's important work despite decreased dues revenues. With the help of Steve Osborn and his talented staff, we were able to publish a new and improved version of this magazine, which recently won first place in a Northern California publications competition sponsored by the Society for Technical Communication (see box).

The MMS Board is always looking for ways to better serve its members and the public; like other organizations, we periodically hold a strategic planning retreat. The next one is planned for early March and will be held in conjunction with the Sonoma County Medical Association's board retreat. In preparation for this event, we recently sent out a survey to both member and nonmember physicians, as well as other stakeholders in the community, to solicit their opinions on the role and expectations of MMS. We will carefully examine the survey responses and do our best to steer MMS in the right direction for the coming years. Stay tuned for the results of our deliberations. ◇

Email: irinadefischer@gmail.com

MARIN MEDICINE WINS TOP AWARD

In January, *Marin Medicine* won first place in the Touchstone publications competition sponsored by the Northern California chapters of the Society for Technical Communication (STC), the world's largest organization of technical writers, editors and designers. The competition drew entries from across the region, including Oracle, Corel and other high-tech giants.

"The quality of the writing, editing, graphics, and production of the publication is extremely high," wrote the competition judges. "[The magazine] promotes the medical community in Marin County very well. For the most part, the material is written by medical professionals for other medical professionals, with patients invited to listen in. All the material is relevant to patient interests and easy to comprehend."

Next up is the STC's international competition, which *Marin Medicine* was able to enter because of its first-place finish in the regional event. Winners of the international showdown will be announced in May.

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